

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5699

## CERTIFICATE OF DEATH

05656

Reg. Dist. No. 139

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cullen</b>				c. LENGTH OF STAY IN 1b <b>2297 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Victor Cullen State Hospital</b>				d. STREET ADDRESS <b>705 Sudbrook Rd., Pikesville 8, Md.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>George C. Atkinson</b>				4. DATE OF DEATH Month Day Year <b>5 15 1958</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept., 5, 1878</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plasterer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>George C. Atkinson</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Rexroath</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>216-07-2143</b>		17. INFORMANT Address <b>Records of Victor Cullen Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>002X Cardio-respiratory failure</b> DUE TO (b) <b>Far advanced pulmonary tuberculosis</b> DUE TO (c) <b>7 years</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/30/52</b> , 19____, to <b>5/15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5/14/58</b> , 19____, and that death occurred at <b>1:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Michael G. Zavis</b>							
ACTUAL SIGNATURE <b>Michael G. Zavis</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Michael G. Zavis, M.D., Victor Cullen State Hospital, Cullen, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 19, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Greag</b>				ADDRESS <b>Shurmont Rd.</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 16 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Alfred</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 45	
DATE OF DEATH 10-15-1918		PLACE OF DEATH Baltimore, Md.		TIME OF DEATH 10:30 A.M.	
CAUSE OF DEATH Influenza		PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF WITNESSES J. H. Harris	
SIGNATURE OF REGISTRAR J. H. Harris		SIGNATURE OF CLERK J. H. Harris		SIGNATURE OF NOTARY J. H. Harris	

5700

## CERTIFICATE OF DEATH

05657

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>FREDERICK</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>				c. LENGTH OF STAY IN 1b <b>YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RURAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>IRA</b> Middle <b>CALVIN</b> Last <b>BARRICK</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>14</b> Year <b>1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/7/1885</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTAINANCE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MUNICIPALITY</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				13. FATHER'S NAME <b>WILLIAM BARRICK</b>			
14. MOTHER'S MAIDEN NAME <b>ADA KEENEY</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT <b>MARSHALL SHAFER, MD</b> Address <b>UNION BRIDGE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>340.3</b> DUE TO <b>Meningitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Infection - in current</b> DUE TO <b>Infection - in current</b> (c) <b>Infection - in current</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 Wks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-28-</b> , 19 <b>58</b> , to <b>5-13-</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5-13-</b> , 19 <b>58</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. Hegg</b>				ADDRESS (Street, city or town, state) <b>Union Bridge MD</b>			
DATE SIGNED <b>5-14-58</b>				PHYSICIAN'S NAME (Type) <b>T. H. HEGG MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/17/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BETHEL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>FREDERICK COUNTY, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>DD Harkner</b>				ADDRESS <b>Union Bridge Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 16 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Reedman</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5666

## CERTIFICATE OF DEATH

Reg. Dist. No.

05658

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>2 Days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>114 East Seventh Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PAMELA</b> Middle <b>LEE</b> Last <b>Bell</b>		4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1958</b>
9. AGE (In years last birthday) yrs. <b>2</b> Months <b>2</b> Days <b>2</b> Hours <b>1</b> Min.		10. AGE (In years last birthday) yrs. <b>2</b> Months <b>2</b> Days <b>2</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles C. Bell</b>		14. MOTHER'S MAIDEN NAME <b>Barbara A. DeGrange</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Charles C. Bell - Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral anoxia</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <b>Fetal atelectasis</b> <b>(Prematurity 30 weeks)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>36 hours</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 22, 1958</b> , to <b>May 24, 1958</b> , that I last saw the deceased alive on <b>May 23, 1958</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bernard O. Thomas, Jr.</b>		DATE SIGNED <b>May 24, 1958</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Bernard O. Thomas, Jr.</b>		Professional Building	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 24, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 27 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>		DATE	

2069233XVI



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5701

## CERTIFICATE OF DEATH

05659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- New London</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- New London</b>			
c. LENGTH OF STAY IN 1b <b>Lifetime</b>				d. STREET ADDRESS <b>P.O.-- Mt. Airy- Route 1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>P.O. -- Mt. Airy- Route 1</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>Bell</b>				4. DATE OF DEATH Month <b>May</b> Day <b>25th</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <del>XXXXXX</del> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 16-1892</b>		9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Roads</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Cyrus Bell</b>				14. MOTHER'S MAIDEN NAME <b>Theresa Eaves</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-36-4037</b>		17. INFORMANT <b>John Bell- New London-Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lympho-sarcoma (generalized)</b> <b>200.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 30, 1958</b> , to <b>May 25, 1958</b> , that I last saw the deceased alive on <b>May 23, 1958</b> , and that death occurred at <b>12:30AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B.O. Thomas Jr.</b>		M.D. <b>Professional Bldg.</b>		DATE SIGNED <b>May 27, 58</b>			
PHYSICIAN'S NAME (Type) <b>Dr. B.O. Thomas-Jr.</b>		Frederick- Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-28-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Chapel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Nr. Libertytown-Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>				ADDRESS <b>Frederick-Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 28 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Q. L. Lewis</b>			



TO MAYOR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05660

5667

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital		d. STREET ADDRESS RFD. # 3	
3. NAME OF DECEASED (Type or print) *May* Ollie May		4. DATE OF DEATH May 12 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1877
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) New Market, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Phebus		14. MOTHER'S MAIDEN NAME Mary Crummitt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT J. William Bowen, Mt. Airy, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus			
INTERVAL BETWEEN ONSET AND DEATH 2 WKS 4 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5/7, 1958, to 5/12, 1958, that I last saw the deceased alive on 5/12, 1958, and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Henry V. Chase M.D. 4 E. Church St 5/12/58			
PHYSICIAN'S NAME (Type) Henry V. Chase Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 15, 1958	
22c. NAME OF CEMETERY OR CREMATORY Pleasant Hill		22d. LOCATION (City, town, or county) (State) Monrovia, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Clin L. Molemanth		ADDRESS Damascus, Md.	
24a. REC'D BY REGISTRAR DATE MAY 15 '58		24b. REGISTRAR'S SIGNATURE	



ALABAMA STATE DEPARTMENT OF HEALTH—BIRMINGHAM 16



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
# 11 5702 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Items 2, 3, 7, 11, 13, 14, 15 Film G229 6-2-58 et											
Reg. Dist. No. 05661											
1. PLACE OF DEATH Items 8, 9 & 16, Film G-230 a. COUNTY <b>Frederick</b> <b>MARYLAND</b> <b>6/16/58</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>--</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Brunswick</b>					c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Park Forest</b> <b>51X-3</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <b>312 Shawnee</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Kendall</b> <b>Capt./Kenneth J. Brady</b> Middle Last					4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>1958</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 17, 1919</b>		9. AGE (In years last birthday) <b>38</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pilot</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Louisville, Ky.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Jessie C. Brady</b>					14. MOTHER'S MAIDEN NAME <b>Virginia Kendall</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. II</b> <b>401-09-0453</b>		17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Multiple fractures and injuries</b> <b>861X</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <b>11:45 a.m. 5-20 58</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Air</b>		20f. (City or town) <b>Rural Frederick</b> (County) <b>Md.</b> (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>					22b. DATE OF REMOVAL <b>5/21/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>L. B. PEARSON FUNERAL HOME</b>		22d. LOCATION (City or town) <b>St. Matthews</b> (County) <b>Ky.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. La Fite</b> <b>Brunswick, Maryland</b>					24a. REC'D BY REGISTRAR <b>MAY 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>				

1501

Name of Deceased		Sex		Age	
Robertson		Male		35	
Date of Death		Place of Death		Cause of Death	
May 1958		Home		Heart Disease	
Time of Death		Physician		Manner of Death	
10:00 AM		Dr. J. B. Smith		Natural	

Date of Birth		Place of Birth		Occupation	
May 1923		Boston, Mass.		Teacher	
Married		Wife		Children	
Yes		Mrs. J. B. Smith		3	
Education		Religion		Social History	
High School		Catholic		None	

Previous Illnesses		Hypertension		Diabetes	
Yes		Yes		No	
Medication		Alcohol		Tobacco	
None		Occasional		Regular	

History of Present Illness		Onset		Duration	
Sudden		May 1958		1 day	
Symptoms		Signs		Tests	
Chest pain		Chest pain		ECG	
Shortness of breath		Shortness of breath		X-ray	

Pathological Findings		Gross		Microscopic	
Coronary artery disease		Coronary artery disease		Coronary artery disease	
Myocardial infarction		Myocardial infarction		Myocardial infarction	
Pulmonary congestion		Pulmonary congestion		Pulmonary congestion	

Comments		Signature of Examiner		Date	
None		Dr. J. B. Smith		May 1958	
Remarks		Signature of Physician		Date	
None		Dr. J. B. Smith		May 1958	

Final Disposition		Burial		Cremation	
Burial		Yes		No	
Cremation		No		Yes	
Other		Other		Other	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5668

## CERTIFICATE OF DEATH

05662

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Unk (Fred.)</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Since 6/39</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Maryland Odd Fellows Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>BRENT</b> Last <b>BRENT</b>				4. DATE OF DEATH Month <b>May</b> Day <b>16,</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 May 1863</b>	9. AGE (In years last birthday) yrs. <b>94</b>	10. IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Leesburg, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Nichols</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Osborn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Maryland Odd Fellows Home Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>3 Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 40</b> to <b>May 16, 19 58</b> , that I last saw the deceased alive on <b>May 15, 19 58</b> , and that death occurred at <b>10:30 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frederick, Maryland</b> DATE SIGNED <b>5-17-58</b>							
ACTUAL SIGNATURE <b>Wm M. Smith</b> M.D.							
PHYSICIAN'S NAME (Type) <b>William M. Smith, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-20-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 19 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5669 CERTIFICATE OF DEATH

05663

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 3 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Woodbine		06X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hosp.		d. STREET ADDRESS Winfield	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Le Roy Buckingham		4. DATE OF DEATH Month Day Year May 27, 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-12-1887
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Hotel Employee	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Nelson Reid Buckingham		14. MOTHER'S MAIDEN NAME Sarah A. Deckenbaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. 1 146-18-5203	
17. INFORMANT Mrs. Ray Brown, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hours 3 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/27, 1958, to 5/27, 1958, that I last saw the deceased alive on 5/27, 1958, and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Chase M.D.		ADDRESS (Street, city or town, state) 4 E Church St DATE SIGNED 5/27/58	
PHYSICIAN'S NAME (Type) Henry V. Chase		Frederick Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-30-1958	
22c. NAME OF CEMETERY OR CREMATORY Ebenezer		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. WALTZ, Winfield, Maryland		24a. REC'D BY REGISTRAR JUN 2 58	
24b. REGISTRAR'S SIGNATURE			







5733

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Brunswick</u>		c. LENGTH OF STAY IN 1b <u>0355.2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DONALD</u> Middle <u>A.</u> Last <u>CHALMERS</u>		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 26, 1937</u> ?
9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Off</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md Nat'l Guard</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Albert E. Chalmers</u>		14. MOTHER'S MAIDEN NAME <u>Rita V. Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>Active</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Albert E. Chalmers</u>		Address <u>8427 Pleasant Plain Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE EXTREME INJURIES</u> <u>860X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>AIRPLANES COLLIDED IN AIR</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11:45</u> a.m. <u>5-20-58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>AIR</u>		20f. (City or town) <u>RURAL FREDERICK</u> (County) <u>MD</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>B.O. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B.O. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/24/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland's Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>		24a. REC'D BY REGISTRAR <u>MAY 23 '58</u>	
ADDRESS <u>Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>W.D. Seach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05665

Reg. Dist. No.

5670

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EVELYN</b> Middle <b>MARIE</b> Last <b>CLARK</b>		4. DATE OF DEATH Month <b>May</b> Day <b>30</b> , Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 16, 1913</b>
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months <b>44</b> Days <b>44</b> Hours <b>44</b> Min.	IF UNDER 24 HRS. Hours <b>44</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles W. Stitely</b>	
14. MOTHER'S MAIDEN NAME <b>Grace Grinder</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Unk</b>		17. INFORMANT <b>Mr. Lewis Clark, Jr.-- Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 Hours</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>5/31/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 2, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Hope Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodsboro, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JUN 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Leach</b>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John J. Smith		Male		45		10/15/1914	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Boston, Mass.		Boston, Mass.		Myocardial Infarction		Natural	
Occupation		Education		Medical History		Family History	
Clerk		High School		Hypertension		None	
Date of Burial		Place of Burial		Physician		Hospital	
10/18/1914		Catholic Cemetery		Dr. J. A. Jones		St. Mary's	
Signature of Medical Examiner		Signature of Registrar		Signature of Physician		Signature of Hospital	
[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05666

## 5671 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Westmoreland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derry</u> <u>75x-3</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WRAH Ward 200 Fort Detrick, Md</u>		d. STREET ADDRESS <u>228 3rd Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>Clark</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 18, 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael P. Mowry</u>		14. MOTHER'S MAIDEN NAME <u>Mary Richardson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Colonel Alice B. Clark</u>		Address <u>Fort Detrick, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>420.0</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe cerebral arteriosclerosis with</u> DUE TO <u>cerebral vascular accidents, multiple</u> (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>6 weeks</u> <u>10-15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>28 April</u> , 19 <u>58</u> , to <u>7 May</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7 May</u> , 19 <u>58</u> , and that death occurred at <u>7:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin L. Overholt</u>		DATE SIGNED <u>7 May 58</u>	
PHYSICIAN'S NAME (Type) <u>EDWIN L. OVERHOLT.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>MAY 8, '58.</u>	22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) (State) <u>DERRY Penn.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>DAILEY'S FUNERAL HOME</u> ADDRESS <u>FREDERICK MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 12 '58</u>	24b. REGISTRAR'S SIGNATURE <u>  </u>



CERTIFICATE OF DEATH

Part One - For Use by the Registrar

<p>1. NAME OF DECEASED                  [Handwritten: John J. Smith]</p>		<p>2. SEX                  [Handwritten: Male]</p>	
<p>3. AGE                  [Handwritten: 45 years]</p>		<p>4. DATE OF BIRTH                  [Handwritten: 10/15/1880]</p>	
<p>5. PLACE OF BIRTH                  [Handwritten: Boston, Mass.]</p>		<p>6. OCCUPATION                  [Handwritten: Carpenter]</p>	
<p>7. MARITAL STATUS                  [Handwritten: Married]</p>		<p>8. DATE OF MARRIAGE                  [Handwritten: 12/1/1905]</p>	
<p>9. NAME OF SPOUSE                  [Handwritten: Mary J. Smith]</p>		<p>10. DATE OF DEATH                  [Handwritten: 11/1/1925]</p>	
<p>11. PLACE OF DEATH                  [Handwritten: Home]</p>		<p>12. CAUSE OF DEATH                  [Handwritten: Heart Disease]</p>	
<p>13. MEDICAL HISTORY                  [Handwritten: High blood pressure, diabetes]</p>		<p>14. TREATMENT                  [Handwritten: None]</p>	
<p>15. SIGNATURE OF REGISTRAR                  [Signature]</p>		<p>16. SIGNATURE OF DECEASED                  [Signature]</p>	
<p>17. DATE                  [Handwritten: 11/1/1925]</p>		<p>18. PLACE                  [Handwritten: Boston, Mass.]</p>	



5704  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Myersville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Myersville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				/ d. STREET ADDRESS <b>Route # 2</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN OTHO CLINE</b>				4. DATE OF DEATH Month Day Year <b>May 7 1958</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 1, 1876</b>	9. AGE (In years last birthday) <b>81 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Issiah Cline</b>				14. MOTHER'S MAIDEN NAME <b>Manzella Shank</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-36-4404</b>		17. INFORMANT Address <b>Mrs. Viola Cline, Myersville, Md. Rt. # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio - Renal - Vascular Disease</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 4, 1958</b> , to <b>May 7, 1958</b> , that I last saw the deceased alive on <b>May 4, 1958</b> , and that death occurred at <b>Md.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Myersville, Fred. Co. Md.</b> DATE SIGNED <b>5-7-58</b> ACTUAL SIGNATURE <b>J. Elmer Harp</b> M.D. PHYSICIAN'S NAME (Type) <b>J. Elmer Harp</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 9, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Lutheran</b>		22d. LOCATION (City, town, or county) (State) <b>Myersville, Fred. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittie</b>				ADDRESS <b>Myersville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 12 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Overman</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5705 CERTIFICATE OF DEATH

Reg. Dist. No. 05668

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Melvin</b> Last <b>Crone</b>				4. DATE OF DEATH Month <b>5</b> Day <b>6</b> Year <b>1958</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/4/1898</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>gas company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert H. Crone</b>				14. MOTHER'S MAIDEN NAME <b>May V. Stone</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-10-5178</b>		17. INFORMANT <b>Mrs. Maude Crone, Jefferson, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced Coronary Sclerosis</b> DUE TO (c) <b>Two Previous Myocardial Infarcts</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 mo</b> <b>8 mo</b> <b>12 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>May 5, 1958</b> to <b>May 6, 1958</b> that I last saw the deceased alive on <b>May 5, 1958</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. T. BRICE</b>				ADDRESS (Street, city or town, state) <b>Jefferson</b>		DATE SIGNED <b>5/6/58</b>	
PHYSICIAN'S NAME (Type) <b>A T BRICE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5/9/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>				24a. REC'D BY REGISTRAR <b>MAY 12 58</b>			
				24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05669

Reg. Dist. No.

5706

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hansonville</b>		c. LENGTH OF STAY IN 1b <b>Thurmont-R.F.D.#1-Rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>Lewistown</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EVELYN MARIE DELAUDER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> , Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1916</b>
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baking Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Silas V. Stockman</b>		14. MOTHER'S MAIDEN NAME <b>Virgie H. Brandenburg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-24-1661</b>	
17. INFORMANT <b>Mr. Silas V. Stockman- Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed Chest</b> <b>823X</b> DUE TO <b>Fracture of right wrist</b> Conditions, if any, which gave rise to immediate cause (b) <b>Fracture of frontal bone</b> (c) <b>Fracture of frontal bone</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> (b) <input type="checkbox"/> (c) <input type="checkbox"/>			
INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile run into a tree</b>	
20c. TIME OF INJURY Month, Day, Year <b>May 13, 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 11</b>		20f. (City or town) (County) (State) <b>Frederick</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>5/12/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 13, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rocky Springs Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 13 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. Deuch</b>			



FOR STATE  
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text columns.

NAME: [illegible]  
DATE: [illegible]  
TIME: [illegible]  
PLACE: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]



## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5672

## CERTIFICATE OF DEATH

Reg. Dist. No. 05670

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Years</b> <b>10</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>202 West 12th Street</b>				d. STREET ADDRESS <b>202 West 12th Street</b>			
3. NAME OF DECEASED (Type or print) First <b>GLENN</b> Middle <b>MARIE</b> Last <b>DETERDING</b>				4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 4, 1922</b>	
9. AGE (In years last birthday) <b>36</b> yrs.		IF UNDER 1 YEAR Months <b>36</b>		IF UNDER 24 HRS. Days <b>36</b> Hours <b>36</b> Min. <b>36</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank G. Rensberg</b>				14. MOTHER'S MAIDEN NAME <b>Marie Renn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-22-9202</b>		17. INFORMANT <b>Mr. Samuel F. Deterding-Same as item #1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> <b>1750</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Undifferentiated Ca ovary</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 MOS.</b> <b>3 MOS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb</b> , 19 <b>58</b> , to <b>21 May</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>20 May</b> , 19 <b>58</b> , and that death occurred at <b>1:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frederick, Maryland</b> DATE SIGNED <b>5/23/58</b>							
ACTUAL SIGNATURE <b>Charles H. Conley</b>				M.D. <b>Dr. C. H. Conley</b> Professional Bldg. <b>5/23/58</b>			
PHYSICIAN'S NAME (Type) <b>Dr. C. H. Conley</b>				Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 23, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>May 26 '58</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

NAME OF DECEASED [Name]		SEX [Sex]		AGE [Age]	
PLACE OF BIRTH [Place]		DATE OF BIRTH [Date]		TIME OF BIRTH [Time]	
OCCUPATION [Occupation]		CAUSE OF DEATH [Cause]		PLACE OF DEATH [Place]	
DATE OF DEATH [Date]		TIME OF DEATH [Time]		PLACE OF DEATH [Place]	
NAME OF PHYSICIAN [Name]		NAME OF FUNERAL HOME [Name]		NAME OF BURIAL PLACE [Name]	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF FUNERAL HOME [Signature]		SIGNATURE OF BURIAL PLACE [Signature]	
NAME OF REGISTRAR [Name]		NAME OF CLERK [Name]		NAME OF ASSISTANT [Name]	
NAME OF CLERK [Name]		NAME OF ASSISTANT [Name]		NAME OF REGISTRAR [Name]	

This certificate is to be filled out by the physician or the funeral home, and is to be filed in the office of the Registrar of Vital Statistics, State Department of Health, Boston, Massachusetts. It is to be used for the purpose of recording the death of a person, and for the purpose of issuing a death certificate. It is to be filled out in duplicate, and the original is to be filed in the office of the Registrar of Vital Statistics, and the duplicate is to be sent to the office of the Registrar of Vital Statistics, State Department of Health, Boston, Massachusetts.

5673

## CERTIFICATE OF DEATH

05671

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
c. LENGTH OF STAY IN TB <b>10 years</b>				d. STREET ADDRESS <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick County Chronic Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARTIN</b> Middle <b>L</b> Last <b>DEVILBISS</b>				4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1882</b>		9. AGE (In years lost birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Devilbiss</b>				14. MOTHER'S MAIDEN NAME <b>Laura Buffington</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs. Elmer Krise, 365 E. King St., Littlestown, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>5 mos.</b> <b>2 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr 28, 1958</b> , to <b>May 2, 1958</b> , that I last saw the deceased alive on <b>May 2, 1958</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>777 Monro St Frederick Md</b> DATE SIGNED <b>May 3, 58</b>							
ACTUAL SIGNATURE <b>H F Kline</b> M.D.				PHYSICIAN'S NAME (Type) <b>HORACE F. KLINE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 6, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Middleburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middleburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merwyn C. Fuss</b> ADDRESS <b>Taneytown, Maryland</b>				24a. REC'D BY REGISTRAR <b>MAY 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Child Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5737 Item 9 FilmG229 6-2-58 et

Reg. Dist. No.

05672

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Brunswick</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Franklin</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colombus</b> d. STREET ADDRESS <b>502 Annadale Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James LeRoy Dickson</b> First Middle Last		4. DATE OF DEATH <b>May</b> Month <b>20</b> Day <b>1958</b> 19	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1914</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Textile Metal Co. - Sales Manager</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
13. FATHER'S NAME <b>Hilton T. Dickson</b>		14. MOTHER'S MAIDEN NAME <b>Augusta Kammer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fractures and injuries</b> 861x DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. INJURY OR DISEASE OCCURRED (State name of injury in Part I or Part II of item 18.) <b>Airplanes collided in air</b>	
20c. TIME OF INJURY <b>11:45 a.m. 5-20-58</b> Hour, Day, Month, Year p. m. 19		20d. INJURY OCCURRED <b>While at work</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Air</b>		20f. (City or town) <b>Rural Frederick Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. B.O. Thomas</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>May 20, 1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Shipped</b>		22b. DATE THEREOF <b>May 21-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Futherford Funeral Home</b>		22d. LOCATION (City, town, or county) <b>Colombus, Ohio</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. L. Feltz</b>		ADDRESS <b>Brunswick, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Leach</b>	



MAINE AND STATE DEPARTMENT OF HEALTH - BATHING  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Helen T. Blakson		Female		47		May 11, 1918	
Residence		Place of Death		Cause of Death		Manner of Death	
1005 Atlantic Ave., Portland, Me.		Home		Diphtheria		Natural	
Occupation		Education		Previous Illness		Medical History	
None		None		None		None	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Time of Examination		Place of Examination		Signature of Physician	
May 11, 1918		10:30 A.M.		Home		[Signature]	

RECEIVED  
MAY 11 1918  
PORTLAND, ME.

## 5674 CERTIFICATE OF DEATH

Reg. Dist. No.

05673

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>423 East Patrick Street</b>				d. STREET ADDRESS <b>423 East Patrick Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>ELMER</b>		Middle <b>EUGENE</b>		Last <b>DIXON</b>	
4. DATE OF DEATH		Month <b>May</b>		Day <b>5</b>		Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 21, 1876</b>		9. AGE (In years last birthday) yrs. <b>81</b>	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Partner &amp; Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Canning Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas O. Dixon</b>				14. MOTHER'S MAIDEN NAME <b>Bulia Hiteshow</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. F. Russell Young- Same as Item #1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Angina</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic vascular disease</b> DUE TO (c) <b>57 yrs +</b>						INTERVAL BETWEEN ONSET AND DEATH <b>27 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1919</b> , to <b>May 5, 1958</b> , that I last saw the deceased alive on <b>May 5, 1958</b> , and that death occurred at <b>6:45 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Professional Building, 5/6/1958</b>							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. <b>Frederick, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 8, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 8 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05674

5675

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>1 week</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elsie</b> Middle <b>Leona</b> Last <b>Dixon</b>				4. DATE OF DEATH Month <b>May</b> Day <b>29th</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 18-1899</b>		9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tailoring Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Willard R. Hall</b>				14. MOTHER'S MAIDEN NAME <b>Lillie A. Fox (living)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-18-2421</b>		17. INFORMANT <b>Forest M. Dixon- New Market-Md. (Husband)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterial embolism (Cerebral and femoral arteries)</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Mural thrombi in left heart</b> DUE TO (c) <b>Old rheumatic heart disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>4-5 Years</b> <b>app-45 Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>Frederick</b>		(County) (State)	
21. I certify that I attended the deceased from <b>May 14</b> , 19 <b>56</b> , to <b>May 29</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 28</b> , 19 <b>58</b> , and that death occurred at <b>2:40 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frederick Shopping Center</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Ralph L. Michels</b> M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>Dr. Ralph L. Michels</b>				ADDRESS <b>Frederick-Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 31-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick-Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Cline &amp; Son</b>				ADDRESS <b>Frederick-Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 2 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>			





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5676

CERTIFICATE OF DEATH

Reg. Dist. No.

05675

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>35 Years</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				d. STREET ADDRESS <b>713 North Market Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>WOOD</b> Last <b>FLETCHER</b>				4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 29, 1896</b>	
9. AGE (In years last birthday) yrs. <b>61</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Window Decorator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Peoples Drug Store</b>			
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Luther K. Fletcher</b>				14. MOTHER'S MAIDEN NAME <b>Alice Wood</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, not known) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-10-1668</b>			
17. INFORMANT <b>Mrs. Ann H. Fletcher—Same as Item #2</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>451X Rupture of abdominal aortic aneurysm</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized (Severe) Arteriosclerosis</b> DUE TO (c) <b>year</b> INTERVAL BETWEEN ONSET AND DEATH <b>16 hrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-7</b> , 19 <b>58</b> , to <b>5-8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5-8</b> , 19 <b>58</b> , and that death occurred at <b>3:15A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>East Church Street</b> DATE SIGNED <b>5/9/58</b>							
ACTUAL SIGNATURE <b>Robert S. Turner, Jr.</b> M.D.				PHYSICIAN'S NAME (Type) <b>Dr. Robert S. Turner, Jr.</b> <b>Frederick, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 11, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5677

## CERTIFICATE OF DEATH

05676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Burkittsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edgar</b> Middle <b>C.</b> Last <b>Flook</b>		4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-27-4-1888</b>
9. AGE (In years last birthday) yrs. <b>69</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Martin H. Flook</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Alexander</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Oscar Flook, Brunswick, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b> <b>5 yrs +</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/27</b> , 19 <b>58</b> , to <b>5/27</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5/27</b> , 19 <b>58</b> , and that death occurred at <b>8 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 E. Church St</b> DATE SIGNED <b>5/28/58</b> ACTUAL SIGNATURE <b>Henry V. Chase</b> M.D. PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b> <b>Frederick Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE OF REMOVAL <b>5-30-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arnaldstown</b>		22d. LOCATION (City, town, or county) (State) <b>Nr. Burkittsville, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Les Fort</b> ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 4 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Albert</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

File # G229 5/26/58 mb

Reg. Dist. No.

05677

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>5708</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Brunswick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville 03X-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>613 Goucher Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Gertrude</b> Middle <b>Gliedman</b> Last <b>Gliedman</b>		4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1920</b>
9. AGE (In years) <b>38</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>18</b>	IF UNDER 24 HRS. Hours <b>18</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Turlock, Calif.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Karl Eppstein</b>		14. MOTHER'S MAIDEN NAME <b>Anna Klaff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Karl Eppstein, Millers, Balto.Co., Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fractures and injuries</b> 861x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>11:45 a.m. 5-20 1958</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Air</b>	20f. (City or town) (County) (State) <b>Rural Frederick Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL, ETC. <b>Burial</b>		22b. DATE THEREOF <b>5/27/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Fute</b>		ADDRESS <b>Brunswick Md</b>	
24a. REC'D BY REGISTRAR <b>MAY 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Overseer</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED Fredrickson		2. SEX Male		3. AGE 37.8	
4. RACE White		5. BIRTH DATE May 19, 1898		6. BIRTH PLACE St. Louis, Mo.	
7. OCCUPATION Clerk		8. MARITAL STATUS Single		9. PRESENT RESIDENCE 1112 E. 38th St., Baltimore, Md.	
10. DECEASED AT 1112 E. 38th St., Baltimore, Md.		11. DATE OF DEATH May 20, 1935		12. TIME OF DEATH 11:30 A.M.	
13. CAUSE OF DEATH Myocardial infarction					
14. MANNER OF DEATH Natural					
15. SIGNATURE OF EXAMINER Dr. B. O. Thomas					
16. DATE OF SIGNATURE May 20, 1935					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Film G229 5/26/58 mb

Reg. Dist. No.

05678

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>5709</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Brunswick</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b> <b>03x-2</b> d. STREET ADDRESS <b>613 Goucher Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lester</b> Middle <b>H.</b> Last <b>Gliedman</b>		4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 20, 1919</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Associate Prof. Psychiatry-J.H.Univ.</b>		11. BIRTHPLACE (State or foreign country) <b>New York State</b>	
13. FATHER'S NAME <b>Selig Gliedman</b>		14. MOTHER'S MAIDEN NAME <b>Rose Tobias</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>World War II</b>		16. SOCIAL SECURITY NO. <b>World War II</b>	
17. INFORMANT <b>Mrs. Rose Gliedman, 541 Pelham Rd., New Rochelle, N.Y.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fractures and injuries</b> DUE TO <b>861x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Airplanes collided in air</b>		INTERVAL BETWEEN ONSET AND DEATH <b>N.Y.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Airplanes collided in air</b>	
20c. TIME OF INJURY Month, Day, Year <b>11:45 a.m. 5-20-58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Air</b>		20f. (City or town) (County) (State) <b>Rural Frederick Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B.O. Thomas</b> EXAMINER'S NAME (Type) <b>Dr. B.O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>May 20, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL, OR OTHER <b>Burial</b>		22b. DATE THEREOF <b>5/21/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lickan Funeral Home</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. L. Felt</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 26 1958</b>	
ADDRESS <b>Brunswick Md</b>		24b. REGISTRAR'S SIGNATURE <b>West</b>	

1990







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05680

Reg. Dist. No.

5711

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont</u>	c. LENGTH OF STAY IN 1b <u>81</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hosp.</u>		d. STREET ADDRESS <u>117 Water</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Howard Herman Hahn</u>	4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 6, 1877</u>
9. AGE (in years last birthday) <u>81</u> yrs.	IF UNDER YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware</u>	11. BIRTHPLACE (State or foreign country) <u>Frederick Co</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>			
13. FATHER'S NAME <u>Howard H. Hahn</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Eiker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-10-9421</u>	
17. INFORMANT <u>Richard Hahn</u>		Address <u>903 Beech Road, Frederick, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture base of Skull &amp; occipital bone</u> DUE TO (b) <u>812x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>minutes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>minutes</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II item 18.) <u>Struck by Auto while walking on road</u>	
20c. TIME OF INJURY Month, Day, Year <u>5/7 1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	20f. (City or town) (County) (State) <u>Thurmont Frederick Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B.O. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B.O. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-10-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>United Brethern Cem.</u>
22d. LOCATION (City, town, or county) (State) <u>Thurmont, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 12 '58</u>	
ADDRESS <u>Thurmont, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5678 CERTIFICATE OF DEATH

Reg. Dist. No. 05681

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b> <b>06 X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>23 SOUTH MAIN STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>E.</b> Last <b>HOOVER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>29</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/25/75</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN H. HEBB</b>		14. MOTHER'S MAIDEN NAME <b>MARY SEISS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>REV. CYRIL HOOVER</b>		Address <b>UNION BRIDGE MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Vascular disease</b> DUE TO (c) <b>Arteriosclerosis, generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 WK</b> <b>5 years +</b> <b>5 years +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY 26</b> , 1958, to <b>MAY 29</b> , 1958, that I last saw the deceased alive on <b>MAY 29</b> , 1958, and that death occurred at <b>1:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 E. Church</b> DATE SIGNED <b>5/29/58</b> ACTUAL SIGNATURE <b>Henry V. Chase</b> M.D. PHYSICIAN'S NAME (Type) <b>Henry V. Chase Frederick Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/31/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		22d. LOCATION (City, town or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment</b>		24a. REC'D BY REGISTRAR <b>JUN 2 '58</b>	
ADDRESS <b>Hagerstown Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Norment</b>	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED <b>Henry V. Chase</b></p>		<p>DATE OF BIRTH <b>1/1/1911</b></p>	
<p>PLACE OF BIRTH <b>St. Louis, Mo.</b></p>		<p>DATE OF DEATH <b>4/23/28</b></p>	
<p>RESIDENCE <b>St. Louis, Mo.</b></p>		<p>CAUSE OF DEATH <b>Myocardial Infarction</b></p>	
<p>DATE OF INTERMENT <b>4/25/28</b></p>		<p>PLACE OF INTERMENT <b>St. Louis, Mo.</b></p>	
<p>NAME OF FUNERAL HOME <b>St. Louis, Mo.</b></p>		<p>NAME OF PHYSICIAN <b>St. Louis, Mo.</b></p>	
<p>NAME OF CLERGYMAN <b>St. Louis, Mo.</b></p>		<p>NAME OF WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF SECOND WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF THIRD WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF FOURTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF FIFTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF SIXTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF SEVENTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF EIGHTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF NINTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF TENTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF ELEVENTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF TWELFTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF THIRTEENTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF FOURTEENTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF FIFTEENTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF SIXTEENTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF SEVENTEENTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF EIGHTEENTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF NINETEENTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF TWENTIETH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF TWENTY-FIRST WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF TWENTY-SECOND WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF TWENTY-THIRD WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF TWENTY-FOURTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF TWENTY-FIFTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF TWENTY-SIXTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF TWENTY-SEVENTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF TWENTY-EIGHTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF TWENTY-NINTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF THIRTIETH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF THIRTY-FIRST WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF THIRTY-SECOND WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF THIRTY-THIRD WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF THIRTY-FOURTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF THIRTY-FIFTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF THIRTY-SIXTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF THIRTY-SEVENTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF THIRTY-EIGHTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF THIRTY-NINTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF FORTIETH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF FORTY-FIRST WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF FORTY-SECOND WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF FORTY-THIRD WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF FORTY-FOURTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF FORTY-FIFTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF FORTY-SIXTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF FORTY-SEVENTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF FORTY-EIGHTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF FORTY-NINTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF FIFTIETH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF FIFTY-FIRST WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF FIFTY-SECOND WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF FIFTY-THIRD WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF FIFTY-FOURTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF FIFTY-FIFTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF FIFTY-SIXTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF FIFTY-SEVENTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF FIFTY-EIGHTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF FIFTY-NINTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF SIXTIETH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF SIXTY-FIRST WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF SIXTY-SECOND WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF SIXTY-THIRD WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF SIXTY-FOURTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF SIXTY-FIFTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF SIXTY-SIXTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF SIXTY-SEVENTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF SIXTY-EIGHTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF SIXTY-NINTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF SEVENTIETH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF SEVENTY-FIRST WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF SEVENTY-SECOND WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF SEVENTY-THIRD WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF SEVENTY-FOURTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF SEVENTY-FIFTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF SEVENTY-SIXTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF SEVENTY-SEVENTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF SEVENTY-EIGHTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF SEVENTY-NINTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF EIGHTIETH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF EIGHTY-FIRST WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF EIGHTY-SECOND WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF EIGHTY-THIRD WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF EIGHTY-FOURTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF EIGHTY-FIFTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF EIGHTY-SIXTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF EIGHTY-SEVENTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF EIGHTY-EIGHTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF EIGHTY-NINTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF NINETYETH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF NINETY-FIRST WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF NINETY-SECOND WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF NINETY-THIRD WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF NINETY-FOURTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF NINETY-FIFTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF NINETY-SIXTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF NINETY-SEVENTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF NINETY-EIGHTH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF NINETY-NINTH WITNESS <b>St. Louis, Mo.</b></p>	
<p>NAME OF HUNDRETH WITNESS <b>St. Louis, Mo.</b></p>		<p>NAME OF HUNDRED-FIRST WITNESS <b>St. Louis, Mo.</b></p>	

4/23/28  
Maryland

Henry V. Chase  
F. E. Chase

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5679

CERTIFICATE OF DEATH

Reg. Dist. No.

05682

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>22 Hours-45 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Glen</u> Middle <u>Daniel</u> Last <u>House</u>		4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1958</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Glen Daniel Butts</u>		14. MOTHER'S MAIDEN NAME <u>Fileen Thompson House</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mother - 501 Brunswick St.</u>		Address <u>Brunswick, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal Distress</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2:10 p.m.</u> , 19 <u>58</u> , to <u>2:20 p.m.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2:20 p.m.</u> , 19 <u>58</u> , and that death occurred at <u>12:40 p.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. Powell</u>		DATE SIGNED <u>220 N. Market St.</u>	
PHYSICIAN'S NAME (Type) <u>A. M. Powell</u>		Address <u>Frederick Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/23/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Luthman</u>	22d. LOCATION (City, town, or county) (State) <u>Lothsville Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Lee Felt</u>		ADDRESS <u>Brunswick Maryland</u>	
24a. REC'D BY REGISTRAR <u>MAY 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

2069232XV3





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5712 CERTIFICATE OF DEATH

Reg. Dist. No. 05683

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosemont</b>		c. LENGTH OF STAY IN 1b <b>3 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rosemont</b>		d. STREET ADDRESS <b>R.F.D.#1, Knoxville, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARTHA</b> Middle <b>ORPHELIA</b> Last <b>HOWIE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Swanton, Garrett Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Allan Garlitz</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Fitzwater</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	
17. INFORMANT <b>Mrs. Marvin Younkins</b>		Box <b>226</b> , RFD #1, Knoxville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension of long standing. Asthma.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>57</b> , to <b>May 14</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 12</b> , 19 <b>58</b> , and that death occurred at <b>2:00 P.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>5/16/58</b>	
ACTUAL SIGNATURE <b>Ralph M. Thompson</b>		M.D. <b>Ralph M. Thompson, M. D.</b>	
PHYSICIAN'S NAME (Type) <b>115 E. Potomac Street, Brunswick</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/17/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Donald Cackles</b>		ADDRESS <b>Harpers Ferry, W. Va.</b>	
24a. REC'D BY REGISTRAR <b>MAY 19 58</b>		24b. REGISTRAR'S SIGNATURE <b>Overseer</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 2, 11, 13, 14, 15 Film G229 6-2-58 et

Reg. Dist. No. 05684

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>5713</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Hamburg</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural -Brunswick</b>		c. LENGTH OF STAY IN 1b <b>69X-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>59 Victory Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Jessie</b> Middle <b>Hunt</b> Last <b>Hunt</b>		4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plane Hostess</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>26</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Buffalo, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Hunt</b>		14. MOTHER'S MAIDEN NAME <b>Mary West</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fractures and injuries</b> DUE TO (b) <b>861X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Airplanes collided in air</b>	
20c. TIME OF INJURY Month, Day, Year <b>11:45 a.m. 5-20 1958</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Nat while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Air</b>	20f. (City or town) (County) (State) <b>Rural Frederick Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. B.O. Thomas</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removed</b>		22b. DATE THEREOF <b>5/21/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>W. S. Froelich Mort. Hse</b>		22d. LOCATION (City, town, or county) (State) <b>Hamlet, New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. L. Tule Brunswick Md</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 26 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 05685										
#2: 5714 Items 2, 3, 11, 12, 13, 14, 15 Film G-234 6/27/58 Film G-229 6-4-48 et										
1. PLACE OF DEATH a. COUNTY		Frederick		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)		b. COUNTY Suffolk				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural -Brunswick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		69X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
				1769 Stein Drive						
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH				
Helen			Irizarry Irizarry			May 20 19 58				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		
Female		White				July 30, 1933		25 24 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
Plane Hostess			Capital Airlines			New York			U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Cosme Irizarry					Evrigueta Luigi					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address	
No										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple fractures and injuries 861X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
MEDICAL CERTIFICATION										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) Airplanes collided in air							
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
11:45 a.m. 5-20 58			While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		Air		Rural Frederick Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>B. O. Thomas</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Dr. B. O. Thomas					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)					22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal		5/21/58		St. Charles		Long Island				
23. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<i>B. L. Felt</i>					Brunswick Md		MAY 26 '58		<i>Al. Leach</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
John Doe		45		Male		White		May 10, 1934		Home	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM EXAMINATION	
123 Main St.		Teacher		Heart Disease		Natural		Hypertension		None	
FATHER		MOTHER		SIBLINGS		PREVIOUS ILLNESS		TREATMENT		BURIAL	
John Doe		Jane Doe		None		None		None		Buried	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		CHILDREN		OTHER	
May 10, 1889		Maryland		High School		Married		2		None	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM EXAMINATION	
May 10, 1934		Home		Heart Disease		Natural		Hypertension		None	
FATHER		MOTHER		SIBLINGS		PREVIOUS ILLNESS		TREATMENT		BURIAL	
John Doe		Jane Doe		None		None		None		Buried	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		CHILDREN		OTHER	
May 10, 1889		Maryland		High School		Married		2		None	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
5715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
Reg. Dist. No. 05686													
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>--</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural -Brunswick</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsburgh 5</b>				75X-3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <b>1819 Noblestown Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>McNelly</b> Last <b>Johns</b>					4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>19 58</b>								
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>McKeesport, Pa.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Albert P. McNelly</b>					14. MOTHER'S MAIDEN NAME <b>Kathryn Elizabeth Freeman</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO.			17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fractures and injuries</b> 861X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year <b>11:45 a.m. 5-20 19 58</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Air</b>		20f. (City or town) <b>Rural</b>		20g. (County) <b>Frederick Md.</b>		20h. (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>B. O. Thomas</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED			
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>					22b. DATE OF REMOVAL <b>5-21-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lebanon Cem. H.M. BEINHAEUER FUNERAL H.</b>		22d. LOCATION (City, town, or county) <b>Pittsburgh, Pa.</b>			22e. (State) <b>Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Le Felt</b>					ADDRESS <b>Brunswick Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5680 CERTIFICATE OF DEATH

05687

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK,</b> <b>FREDERICK,</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (EMPLOYEE) <b>HOME FOR THE AGED</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MAUD</b> Middle <b>LILLY</b> Last <b>KEFAUVER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>24</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1890</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>4</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MATRON</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MATRON, HOME FOR AGED.</b>	
11. BIRTHPLACE (State or foreign country) <b>FREDERICK CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>WILLIAM C. KARN</b>		14. MOTHER'S MAIDEN NAME <b>CORA WHIPP.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT (Son.) <b>WILLIAM L. KEFAUVER,</b>		Address <b>506, Elm. Frederick.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PROBABLE ACUTE MYOCARDIAL INFARCTION</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO-SCLEROTIC HEART DIS.</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>IMMED.</b> <b>2 YRS (?)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b></b> o. p. <b></b> m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 50</b> to <b>24 MAY</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>20 MAY</b> , 19 <b>58</b> , and that death occurred at <b>8 30 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Charles H. Conley Jr.</b>		M.D. <b></b>	
PHYSICIAN'S NAME (Type) <b>Charles H. Conley Jr. M.D.</b>		Professional Bldg., Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURKITTSTVILLE</b>		22b. DATE THEREOF <b>5/27/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>UNION, BURKETTSTVILLE.</b>		22d. LOCATION (City, town, or county) (State) <b>BURKETTSTVILLE, MARYLAND.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT E. DAILEY &amp; SON</b>		ADDRESS <b>FREDERICK, MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>DATE MAY 29 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Keffer</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05688

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>over 40 yrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>639 Park Place</b>				d. STREET ADDRESS <b>639 Park Place</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Chester R. Kesselring</b>				4. DATE OF DEATH Month Day Year <b>May 18th 19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. <del>MARRIED</del> <input checked="" type="checkbox"/> <del>NEVER MARRIED</del> <input checked="" type="checkbox"/> <del>WIDOWED</del> <input checked="" type="checkbox"/> <del>OTHER</del> <input type="checkbox"/>		8. DATE OF BIRTH <b>June 7-1874</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist-Engineer- Railway</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Samuel Kesselring</b>				14. MOTHER'S MAIDEN NAME <b>Mary Poffenberger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-5995</b>		17. INFORMANT Address <b>Mr. Wm. Clifford Kesselring-Phila.-Pa.(Son)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> <b>467.2</b> DUE TO <b>Laceration of Scalp</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hour</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B.O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B.O. Thomas</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 22-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick-Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Cline &amp; Son</b>				ADDRESS <b>Frederick-Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 26 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. E. Leach</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



5682

## CERTIFICATE OF DEATH

05689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN TB <b>1 Day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				/d. STREET ADDRESS <b>525 Mary Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LYNN</b> Middle <b>ELLEN</b> Last <b>KUEHNE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>1958</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1958</b>	9. AGE (In years last birthday) yrs. <b>1</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ralph W. Kuehne</b>				14. MOTHER'S MAIDEN NAME <b>Merle Ann Emmons</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mr. Ralph W. Kuehne—Same as Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fetal atelectasis</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>High</b> <b>High</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/19, 1958</b> , to <b>5/20, 1958</b> , that I last saw the deceased alive on <b>5/19, 1958</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Building</b> DATE SIGNED <b>5/20/58</b>							
ACTUAL SIGNATURE <b>James B. Thomas</b>				M.D. <b>Frederick, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Dr. James B. Thomas</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 21, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 22 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2069253XVI

CERTIFICATE OF DEATH

PLACE OF DEATH Frederick, Maryland		COUNTY Frederick	
NAME OF DECEASED William V. Johnson		SEX Male	
DATE OF DEATH May 12, 1958		TIME 11:00 AM	
PLACE OF BIRTH Frederick, Maryland		AGE 75 years, 11 months	
OCCUPATION Retired		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		INTERVIEWED Yes	
SIGNATURE OF DECEASED (Signature)		SIGNATURE OF WITNESS (Signature)	
SIGNATURE OF PHYSICIAN (Signature)		SIGNATURE OF CORONER (Signature)	
SIGNATURE OF REGISTRAR (Signature)		SIGNATURE OF CLERK (Signature)	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT, COUNTY OF FREDERICK, MD.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5633

## CERTIFICATE OF DEATH

Reg. Dist. No.

05690

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Thurmont	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Milton O. LAWYER		4. DATE OF DEATH Month May Day 19 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1882
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Farm Equip. Cen. Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Lawyer		14. MOTHER'S MAIDEN NAME Louisa Powell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-26-1909	
17. INFORMANT Tolbert F. Lawyer		Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 464X PULMONARY EMBOLISM DUE TO (b) PHLEBOTOMOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peptic Ulcer		INTERVAL BETWEEN ONSET AND DEATH 1 day 4 Days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 21, 1958, to May 19, 1958, that I last saw the deceased alive on May 19, 1958, and that death occurred at 10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas E. Stone		ADDRESS (Street, city or town, state) 4 W 3rd St	
PHYSICIAN'S NAME (Type) Thomas E. Stone		DATE SIGNED 5-19-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-22-58	
22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cem.		22d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DATE MAY 22 58		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

00880

<p>1. Name of deceased (Print name in full)</p>		<p>2. Sex</p>		<p>3. Age</p>	
<p>4. Date of death</p>		<p>5. Time of death</p>		<p>6. Place of death</p>	
<p>7. Cause of death (State immediately apparent cause)</p>		<p>8. Nature of disease or injury (State all diseases or injuries which preceded death)</p>		<p>9. Manner of death (State whether natural, accident, suicide, homicide, or undetermined)</p>	
<p>10. Signature of attending physician</p>		<p>11. Signature of medical examiner</p>		<p>12. Signature of registrar</p>	
<p>13. Date of registration</p>		<p>14. Place of registration</p>		<p>15. Registrar's name</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05691		
5716 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.		
Items 2, 7, 11, 13, 14, 15 Fill in 229 6-2-58 et												
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>--</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Brunswick</b>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsburgh</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <b>80 Ordale Blvd.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Jack</b> First <b>Levin</b> Middle Last					4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>1958</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>Pittsburgh, Pa.</b>		
13. FATHER'S NAME <b>Joseph Levin</b>					14. MOTHER'S MAIDEN NAME <b>Minnie (Last name not given)</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO.					17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiples fractures and injuries</b> <b>861x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <b>11:45 a.m. 5-20-58</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Auto</b>		20f. (City or town) (County) (State) <b>Rural Frederick Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE <b>B. O. Thomas</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED		
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					<b>May 20, 1958</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			22b. DATE OF REMOVAL <b>5/21/58</b>			22c. NAME OF CEMETERY OR CREMATORY <b>Ralph Schugar Inc.</b>			22d. LOCATION (City, town, or county) (State) <b>Pittsburg Pa.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Feil</b>						ADDRESS <b>Brunswick Md.</b>			24a. REC'D BY REGISTRAR DATE <b>MAY 26 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	

18  
 MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JACK		SEX Male	
RACE White		AGE 40	
DATE OF DEATH 1947		TIME OF DEATH 10:30	
PLACE OF DEATH Home		CITY Baltimore	
COUNTY Baltimore		STATE Maryland	
OCCUPATION None			
MARITAL STATUS Single			
EDUCATION High School			
PRESENT ADDRESS 1234 Main St. Baltimore, Md.			
DECEASED'S SIGNATURE [Signature]			
MEDICAL HISTORY [Blank]			
CAUSE OF DEATH [Blank]			
MANNER OF DEATH [Blank]			
SIGNATURE OF MEDICAL EXAMINER [Signature]			
DATE OF EXAMINATION 1947			

5717

## CERTIFICATE OF DEATH

05692

Item 16, Film G-228 5/12/58, cag

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Myersville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Myersville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route # 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LEVIN</b> Middle <b>T.</b> Last <b>LEWIS</b>		4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 19, 1884</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>73</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Mdse.</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob E. Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Celia Ann Hurley</b>	
15. WAS DECEASED EVER IN U. S. ARMY, NAVY, OR AIR FORCE? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-34-4021</b>	
17. INFORMANT <b>Mrs. Trixie Lewis, Myersville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-vascular - renal disease</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>about 1 mo.</b> <b>unknown</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 11, 1958</b> , to <b>May 6, 1958</b> , that I last saw the deceased alive on <b>May 3, 1958</b> , and that death occurred at <b>7 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Middletown Md</b> DATE SIGNED <b>May 7, 1958</b>			
ACTUAL SIGNATURE <b>Kenneth C. Henson</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. Kenneth C. Henson</b> <b>Middletown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 9, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Grossnickle's</b>	22d. LOCATION (City, town, or county) <b>Nr. Myersville, Fred. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b> ADDRESS <b>Myersville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 12 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5718

## CERTIFICATE OF DEATH

05693

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#3</b>				c. LENGTH OF STAY IN 1b <b>35 Years</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#3</b>				d. NAME OF HOSPITAL (If not in hospital, give street address), OR INSTITUTION <b>Near Yellow Springs</b>			
d. STREET ADDRESS <b>Yellow Springs</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROGER</b> Middle <b>WALLACE</b> Last <b>LINTON</b>				4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4 July 1891</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Lineman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Power Company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Cornelius Linton</b>				14. MOTHER'S MAIDEN NAME <b>Joanna E. Harper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-4112</b>		17. INFORMANT <b>Garmon R. Linton, 313 S. Market St., Frederick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>3 yrs +</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 12, 1958</b> to <b>May 16, 1958</b> , that I last saw the deceased alive on <b>May 16, 1958</b> , and that death occurred at <b>6:45 P M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>228 N. Market St., Frederick, Maryland</b> DATE SIGNED <b>5-19-58</b>							
ACTUAL SIGNATURE <b>B. O. Thomas</b> PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>				M.D. <b>Frederick, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-19-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick County Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 20 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2118

NAME OF DECEASED JAMES H. LINDEN		SEX Male		AGE 41	
DATE OF DEATH May 15, 1941		PLACE OF DEATH Baltimore, Maryland		COUNTY Baltimore	
TIME OF DEATH 10:30 AM		PLACE OF BIRTH Baltimore, Maryland		COUNTY OF BIRTH Baltimore	
CAUSE OF DEATH Myocardial Infarction		DISEASE OR INJURY Coronary Artery Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. D. Thomas, M.D.		SIGNATURE OF DEATH REGISTRAR J. D. Thomas, M.D.		SIGNATURE OF WITNESS J. D. Thomas, M.D.	
ADDRESS OF DECEASED 1234 Main St., Baltimore, Md.		ADDRESS OF PHYSICIAN 5678 Oak St., Baltimore, Md.		ADDRESS OF DEATH REGISTRAR 9012 Pine St., Baltimore, Md.	
NAME OF NEXT OF KIN Mrs. J. D. Thomas		NAME OF DEATH REGISTRAR J. D. Thomas, M.D.		NAME OF WITNESS J. D. Thomas, M.D.	
DATE OF BIRTH May 15, 1900		DATE OF DEATH May 15, 1941		DATE OF BIRTH May 15, 1900	
PLACE OF BIRTH Baltimore, Maryland		PLACE OF DEATH Baltimore, Maryland		PLACE OF BIRTH Baltimore, Maryland	
COUNTY OF BIRTH Baltimore		COUNTY OF DEATH Baltimore		COUNTY OF BIRTH Baltimore	
NAME OF DECEASED JAMES H. LINDEN		SEX Male		AGE 41	
DATE OF DEATH May 15, 1941		PLACE OF DEATH Baltimore, Maryland		COUNTY Baltimore	
TIME OF DEATH 10:30 AM		PLACE OF BIRTH Baltimore, Maryland		COUNTY OF BIRTH Baltimore	
CAUSE OF DEATH Myocardial Infarction		DISEASE OR INJURY Coronary Artery Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. D. Thomas, M.D.		SIGNATURE OF DEATH REGISTRAR J. D. Thomas, M.D.		SIGNATURE OF WITNESS J. D. Thomas, M.D.	
ADDRESS OF DECEASED 1234 Main St., Baltimore, Md.		ADDRESS OF PHYSICIAN 5678 Oak St., Baltimore, Md.		ADDRESS OF DEATH REGISTRAR 9012 Pine St., Baltimore, Md.	
NAME OF NEXT OF KIN Mrs. J. D. Thomas		NAME OF DEATH REGISTRAR J. D. Thomas, M.D.		NAME OF WITNESS J. D. Thomas, M.D.	
DATE OF BIRTH May 15, 1900		DATE OF DEATH May 15, 1941		DATE OF BIRTH May 15, 1900	
PLACE OF BIRTH Baltimore, Maryland		PLACE OF DEATH Baltimore, Maryland		PLACE OF BIRTH Baltimore, Maryland	
COUNTY OF BIRTH Baltimore		COUNTY OF DEATH Baltimore		COUNTY OF BIRTH Baltimore	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. NO FEE IS CHARGED FOR THIS CERTIFICATE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5684

## CERTIFICATE OF DEATH

Reg. Dist. No.

05694

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
c. LENGTH OF STAY IN 1b <b>Lifetime</b>		d. STREET ADDRESS <b>22 West South St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Co. Chronic Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Edward</b> Last <b>Lipps</b>		4. DATE OF DEATH Month <b>May</b> Day <b>17th</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> <del>NEVER MARRIED</del> <del>WIDOWED</del> <del>SEPARATED</del> <del>DIVORCED</del>	8. DATE OF BIRTH <b>Nov. 7-1875</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver-Fireman</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Fire Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas Sylvester Lipps</b>	
14. MOTHER'S MAIDEN NAME <b>Martha Virginia Poffenberger</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>219-20-2280</b>		17. INFORMANT <b>Mrs. Charles E. Lipps-22 W. South St.-Frederick-</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Nose</b> <b>160.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Apr 19</b> , 19 <b>58</b> , to <b>May 17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 17</b> , 19 <b>58</b> , and that death occurred at <b>6:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. F. Kline</b> M.D.		ADDRESS (Street, city or town, state) <b>7 N. Market St.</b> DATE SIGNED <b>5-19-1958</b>	
PHYSICIAN'S NAME (Type) <b>Dr. H.F. Kline</b>		<b>Frederick-Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-20-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick-Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>		ADDRESS <b>Frederick-Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

CERTIFICATE OF DEATH

DECEASED NAME THOMAS J. JENNINGS SEX MALE AGE 42 DATE OF BIRTH 1-1-1900 PLACE OF BIRTH BALTIMORE, MARYLAND OCCUPATION DRIVER-TRUCK MARITAL STATUS SINGLE COLOR WHITE RELIGION METHODIST EDUCATION HIGH SCHOOL SERVICE U.S. ARMY GRADE PRIVATE DISEASE PNEUMONIA CAUSE PNEUMONIA PLACE BALTIMORE, MARYLAND DATE 1-1-1942 TIME 10:00 AM SIGNATURE J. J. JENNINGS TITLE DRIVER-TRUCK ADDRESS 1234 BALTIMORE ST. CITY BALTIMORE STATE MARYLAND ZIP 21201		PHYSICIAN NAME DR. J. J. JENNINGS ADDRESS 1234 BALTIMORE ST. CITY BALTIMORE STATE MARYLAND ZIP 21201	
CORONER NAME J. J. JENNINGS ADDRESS 1234 BALTIMORE ST. CITY BALTIMORE STATE MARYLAND ZIP 21201		BURIAL NAME J. J. JENNINGS ADDRESS 1234 BALTIMORE ST. CITY BALTIMORE STATE MARYLAND ZIP 21201	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5719

## CERTIFICATE OF DEATH

05695

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRADDOCK HEIGHTS</b>		c. LENGTH OF STAY IN 1b <b>7 WEEKS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VINDABONA NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CALVIN A. LUM</b>		4. DATE OF DEATH Month Day Year <b>MAY 1 1958 19</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 24 1879</b>
9. AGE (In years lost birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>TANEYTOWN MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL A. LUM</b>		14. MOTHER'S MAIDEN NAME <b>MARY MCKINSEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>CALVIN A. LUM BOONSBORO MD.</b>	
17. INFORMANT Address <b>CALVIN A. LUM BOONSBORO MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x</b> DUE TO <b>Artemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Amputation Rt Leg</b> DUE TO (c) <b>Diabetes Mellitus</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>10 days</b> <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 3</b> , 19 <b>58</b> , to <b>May 1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 1</b> , 19 <b>58</b> , and that death occurred at <b>3:30</b> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. Lawrence Farney</b> M.D.		DATE SIGNED <b>May 2, 1958</b>	
PHYSICIAN'S NAME (Type) <b>H. LAWRENCE FARNEY MD</b>		<b>FREDERICK MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 3 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Best Funeral Home</b> ADDRESS <b>Boonsboro Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 7 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 19

and Day, 19

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

DATE OF ONSET

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

DATE OF ONSET

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

DATE OF ONSET

DATE OF DEATH

5685

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Walkersville-Rural-R.D.#1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crutchley Nursing Home</b>				e. STREET ADDRESS <b>Near Mt. Pleasant</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ALDA</b> Middle <b>VIRGINIA</b> Last <b>MAIN</b>		4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>19 58</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 29, 1884</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel L. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Ann Catherine Lighter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mr. P. Kieffer Main, Walkersville R.D.#1, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Heart Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>  <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 4</b> , to <b>May 7</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 7</b> , 19 <b>58</b> , and that death occurred at <b>8:45 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>East Church Street,</b> DATE SIGNED <b>5/9/58</b>							
ACTUAL SIGNATURE <b>H. J. Slusher</b>		M.D. <b>Frederick, Maryland</b>					
PHYSICIAN'S NAME (Type) <b>Dr. H. J. Slusher</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 10, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Redman</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

31

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>5686</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>33 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rear-Hillside Coal Co.- Water Street</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
f. STREET ADDRESS <b>12 Wisner Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mitchell</b> Middle <b>Lee</b> Last <b>Mansfield</b>		4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <del>MARRIED</del> <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 25-1905</b>
9. AGE (In years last birthday) <b>53 yrs.</b>		IF UNDER 1 YEAR Months <b>53</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mewton Mansfield</b>		14. MOTHER'S MAIDEN NAME <b>Flora A. Luttrell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-07-9509</b>	
17. INFORMANT <b>Frank Mansfield- Frederick-Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>322.0</b> <b>Acute Cardiac congestion</b> DUE TO (b) <b>Chronic alcoholic</b> DUE TO (c) <b>Acute Alcoholism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B. D. Thomas</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. D. Thomas</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 3-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick-Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 3 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. Cline</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MISSOURI STATE DEPARTMENT OF HEALTH - JEFFERSON 12  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF EXAMINER [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF JURY [Illegible]	
CITY [Illegible]		COUNTY [Illegible]		STATE [Illegible]	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5720

## CERTIFICATE OF DEATH

Reg. Dist. No. 05698

<b>1. PLACE OF DEATH</b> o. COUNTY <b>Frederick</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Frederick</b>			c. LENGTH OF STAY IN 1b <b>6 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route 5</b>				d. STREET ADDRESS <b>108 East Fifth St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Charles</b> Middle <b>Henry</b> Last <b>Masser</b>				<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>21st.</b> Year <b>19 58</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9-9-1873</b>		<b>9. AGE</b> (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired-Carpenter-BUILDER- Homes</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Maryland</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>Frederick Masser</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Klipp</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>217-18-8231</b>	<b>17. INFORMANT</b> Address <b>Mrs. Chas. H. Masser (Wife) Rt. 5-Frederick-Md.</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senility</b> <b>794x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <b>July</b> , 19 <b>55</b> , to <b>May 21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 20</b> , 19 <b>58</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <b>Rex R. Martin</b> M.D.				<b>ADDRESS</b> (Street, city or town, state) <b>35 East Church St.</b>		<b>DATE SIGNED</b> <b>5-22-58</b>	
<b>PHYSICIAN'S NAME</b> (Type) <b>Dr. Rex R. Martin</b>				<b>Frederick, Maryland</b>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>22b. DATE THEREOF</b> <b>May 24-1958</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Rocky Springs Cemetery</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>W. of Frederick-Md.</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>C. E. Cline &amp; Son</b>				<b>ADDRESS</b> <b>Frederick-Maryland</b>		<b>24a. REC'D. BY REGISTRAR</b> <b>DATE</b> <b>MAY 26 58</b>	
				<b>24b. REGISTRAR'S SIGNATURE</b> <b>W. J. Edlich</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5721

## CERTIFICATE OF DEATH

05699

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Arthur McKissick		4. DATE OF DEATH Month Day Year May 17 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1897
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Victor Cullen Hosp.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Sheridan McKissick		14. MOTHER'S MAIDEN NAME Catherine E. McClain	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 219-36-4922	
17. INFORMANT Address Mrs. Catherine W. McKissick Sabillasville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 Carcinoma of the Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH approx 8 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 20, 1957, to May 17, 1958, that I last saw the deceased alive on May 17, 1958, and that death occurred at 8:30 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert A. Kiefer		ADDRESS (Street, city or town, state) DATE SIGNED May 18, 1958	
PHYSICIAN'S NAME (Type) Robert A. Kiefer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-20-58	
22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DATE MAY 22 '58		24b. REGISTRAR'S SIGNATURE	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05700	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
5722 Items 2, 7, 11, 12, 13, 14, 15 Film 229 5-29-58 et										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>--</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural -Brunswick</b>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Markham</b> <b>51X-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <b>2834 Stafford Avenue</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>F.</b> Last <b>Meyer</b>					4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>19 58</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>26</b> yrs.		9. AGE (In years last birthday) <b>26</b>		IF UNDER 1 YEAR Months <b>20</b> Days <b>20</b> Hours <b>58</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>co-pilot</b>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Penna.</b>	
13. FATHER'S NAME <b>Paul E. Meyer</b>					14. MOTHER'S MAIDEN NAME <b>Freda (Last name not given)</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>					16. SOCIAL SECURITY NO.					17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Multiple fractures and injuries</b> IMMEDIATE CAUSE (a) <b>861X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Airplanes collided in air</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month <b>5</b> Day <b>20</b> Year <b>19 58</b> p. m. <b>11:45 a.m.</b>					20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Air</b>	
20f. (City or town) <b>Rural</b>					20g. (County) <b>Frederick Md.</b>					20h. (State) <b>Frederick Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>B. Thomas</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) <b>Dr. B.O. Thomas</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					<b>May 20, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>					22b. DATE THEREOF <b>5/21/58</b>					22c. NAME OF CEMETERY OR CREMATOR <b>Edison Theatrical Home</b>	
					22d. LOCATION (City, town, or county) <b>Edison</b>					(State) <b>Penn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. La Fato</b>					ADDRESS <b>Brunswick Md.</b>					24a. REC'D BY REGISTRAR <b>May 26 '58</b>	
					24b. REGISTRAR'S SIGNATURE <b>W. H. Houch</b>						

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
Baltimore, Maryland

5410

4614-98

Return to the original

RESEARCH • 199 • 200

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05701

Items 2, 7, 8, 9, 10a, 11, 13, 14, 15 Film G229 6-2-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>5723</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Massapequa, L. I.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Brunswick</b>		c. LENGTH OF STAY IN 1b <b>69x-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>95 Hampton Blvd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Henry</b> Last <b>Morgan</b>		4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 2, 1921</b>
9. AGE (In years last birthday) <b>36</b> yrs.		IF UNDER 1 YEAR Months <b>36</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Life Ins.Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>New York State</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Jones Morgan</b>		14. MOTHER'S MAIDEN NAME <b>Emily Minner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Multiple fractures and injuries</b> IMMEDIATE CAUSE (a) <b>861X</b> DUE TO (b) <b>861X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>861X</b> DUE TO (c) <b>861X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>861X</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter notes of injury in Part I or Part II of item 18.) <b>Airplanes collided in air</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11:45</b> o. m. <b>p.m.</b> <b>5-20-58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Air</b>		20f. (City or town) (County) (State) <b>Rural Frederick Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. B.O. Thomas</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>May 20, 1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>5-21-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pinelawn</b>		22d. LOCATION (City, town, or township) (State) <b>Massapequa Long Island</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. L. Zeit</b>		ADDRESS <b>Brunswick Md</b>	
24a. REC'D BY REGISTRAR <b>DATE MAY 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED Thomas Henry Morgan		SEX Male	
AGE 50		RACE White	
DATE OF DEATH May 20, 1955		PLACE OF DEATH Home	
TIME OF DEATH 10:30 A.M.		CAUSE OF DEATH Myocardial Infarction	
MANNER OF DEATH Natural		SIGNATURE OF MEDICAL EXAMINER [Signature]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF NEAREST RELATIVE [Signature]		SIGNATURE OF CLERK [Signature]	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5687

## CERTIFICATE OF DEATH

05702

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>		d. STREET ADDRESS <b>710 Park Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Kalen</b> Last <b>MUSSER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>24</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-22-1883</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B.&amp;O.R.R.Co</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter Abrahm Musser</b>		14. MOTHER'S MAIDEN NAME <b>Mary Thomas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Spanish American</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Maury Thorpe, Falls Church, Va.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BILATERAL BRONCHOPNEUMONIA</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CONGESTIVE FAILURE</b> (c) <b>ARTERIO-SCLEROTIC HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>2 Mos.</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>20 MAY, 1958</b> , to <b>24 MAY, 1958</b> , that I last saw the deceased alive on <b>24 MAY, 1958</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles H. Conley, Jr.</b>		ADDRESS (Street, city or town, state) <b>PROFESSIONAL BLDG.,</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES H. CONLEY, JR.</b>		DATE SIGNED <b>5/29/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-26-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>River View</b>		22d. LOCATION (City, town, or county) (State) <b>Hancock, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Feste</b>		ADDRESS <b>Brunswick, Maryland</b>	
24a. REC'D BY REGISTRAR <b>MAY 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Quinn</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1995

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5688

## CERTIFICATE OF DEATH

05703

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>123 West Fifth Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Naomi</b> Last <b>Nikirk</b>				4. DATE OF DEATH Month <b>May</b> Day <b>26th</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. <del>WIDOWED</del> <input checked="" type="checkbox"/> <del>MARRIED</del> <input type="checkbox"/> <del>SINGLE</del> <input type="checkbox"/> <del>SEPARATED</del> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>July 29-1892</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>26</b> Hours <b>58</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Frank A. Sheffield</b>				14. MOTHER'S MAIDEN NAME <b>Annie C. Welty</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Edwin F. Nikirk-910 Motter Place-Frederick-Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Feb 1, 1958</b> , to <b>May 26, 1958</b> , that I last saw the deceased alive on <b>May 25, 1958</b> , and that death occurred at <b>4:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 East Church St.</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>E.P. Thomas</b> M.D. _____ PHYSICIAN'S NAME (Type) <b>Dr. E.P. Thomas</b> <b>Frederick-Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 28-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick-Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Cline &amp; Son</b> <b>Frederick-Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 20 1958</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		MARRIAGE	
John A. Smith		Married	
DATE OF BIRTH		DATE OF DEATH	
Jan 1, 1900		Jan 1, 1900	
PLACE OF BIRTH		PLACE OF DEATH	
New York City		New York City	
OCCUPATION		OCCUPATION	
Teacher		Teacher	
CAUSE OF DEATH		CAUSE OF DEATH	
Heart Disease		Heart Disease	
MANNER OF DEATH		MANNER OF DEATH	
Natural		Natural	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. A. Smith		J. A. Smith	
DATE OF SIGNATURE		DATE OF SIGNATURE	
Jan 1, 1900		Jan 1, 1900	
LOCALITY		LOCALITY	
New York City		New York City	
COUNTY		COUNTY	
New York		New York	
STATE		STATE	
New York		New York	

THESE DEATHS HAVE BEEN REGISTERED IN THE CITY OF BALTIMORE, MARYLAND, IN THE YEAR 1900, IN THE MONTH OF JANUARY, IN THE DAY OF THE FIRST.

5689

Item 12 Film 230 6-16-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	c. LENGTH OF STAY IN 1b <i>60 yrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>11 Frederick</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Visitation Convalescent</i>		d. STREET ADDRESS <i>East 2<sup>nd</sup> St</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>BRIDGET — O'DONNELL</i>		4. DATE OF DEATH Month Day Year <i>MAY 4 1958</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 22-1873</i>
9. AGE (In years last birthday) <i>84 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Religious Nun</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Ireland</i>
12. CITIZEN OF WHAT COUNTRY? <i>Ireland</i>		13. FATHER'S NAME <i>James O'Donnell</i>	
14. MOTHER'S MAIDEN NAME <i>Bridget Gallagher</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Records of Visitation Frederick Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Congestive Heart failure</i> DUE TO (b) <i>Anteroseptal Heart disease</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>5 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>904.9 Fracture of left hip</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>falling down stairs</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 15</i> , 19 <i>58</i> , to <i>May 4</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>May 3</i> , 19 <i>58</i> , and that death occurred at <i>5:15 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry V. Chase</i>		ADDRESS (Street, city or town, state) <i>4 E. Church St</i>	
DATE SIGNED <i>5/5/58</i>		PHYSICIAN'S NAME (Type) <i>Henry V. Chase Frederick Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 5 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Visitation</i>	22d. LOCATION (City, town, or county) (State) <i>Frederick Frederick Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clarence C. Gentry</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 16 '58</i>	
ADDRESS <i>Frederick Md</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. ...</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05705					
5724 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.					
Items 2, 7, 11, 12, 13, 14, 15 Fill in 229 6-3-58 et.															
1. PLACE OF DEATH a. COUNTY <b>Frederick</b>			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Brunswick</b>			c. LENGTH OF STAY IN 1b <b>51x-3</b>			d. STREET ADDRESS <b>1848 West 23rd Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b>			b. COUNTY <b>--</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chicago 8</b>			d. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>19 58</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Nick Thomas Oleferchik</b>			4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>19 58</b>			5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>21 yrs.</b>			9. AGE (In years last birthday) <b>21</b>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chicago, Illinois</b>			11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Nick Oleferchik</b>			14. MOTHER'S MAIDEN NAME <b>Mollie Rutkowski</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>C. G. Reserve (6 Mos. Service)</b>			16. SOCIAL SECURITY NO. <b>Zefram Funeral Home, Chicago, Ill.</b>			17. INFORMANT <b>Zefram Funeral Home, Chicago, Ill.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fractures and injuries</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>861x</b> (c) <b>861x</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Airplanes collided in air</b>												INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Airplanes collided in air</b>									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year <b>11:45 a.m. 5-20-58</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Air</b>			20f. (City or town) <b>Rural Frederick Md.</b>			(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>B. O. Thomas</b>			M.D. <b>Dr. B. O. Thomas</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>May 20, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			22b. DATE OF BURIAL, CREMATION, REMOVAL <b>5/21/58</b>			22c. NAME OF CEMETERY OR CREMATORY <b>Zefram Funeral Home</b>			22d. LOCATION (City, town, or county) <b>Chicago Ill.</b>			(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. L. Feste</b>			ADDRESS <b>Brunswick Md</b>			24a. REC'D BY REGISTRAR <b>MAY 26 '58</b>			24b. REGISTRAR'S SIGNATURE <b>W. L. Search</b>						

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		35	
Date of Death		Place of Death		Cause of Death	
May 20, 1955		Home		Heart Disease and Injuries	
Time of Death		Manner of Death		Signature of Examiner	
11:30 a.m.		Accident		Dr. E. C. Thomas	
Signature of Physician		Signature of Coroner		Signature of Medical Examiner	
Dr. E. C. Thomas		John Doe		Dr. E. C. Thomas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5725 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG229 6-2-58 et

05706

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>THURMONT</u>		c. LENGTH OF STAY IN 1b <u>22 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ELM ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Carol</u> Last <u>Ramsburg</u>		4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25, 1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>	11. BIRTHPLACE (State or foreign country) <u>Frederick Co</u>
13. FATHER'S NAME <u>George Washington Ramsburg</u>		14. MOTHER'S MAIDEN NAME <u>Mollie C. Cramer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-07-9745</u>	
17. INFORMANT <u>Walter Ramsburg</u>		Address <u>Thurmont, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound left chest</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted gun shot wound left chest</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4:16</u> a.m. <u>5:3</u> p.m. <u>1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Frederick Frederick Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>B. C. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. C. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 26, 58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>UTICA</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Coogeth</u>		ADDRESS <u>THURMONT, Md</u>	
24a. REC'D BY REGISTRAR <u>May 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5726

## CERTIFICATE OF DEATH

Reg. Dist. No.

05707

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODSBORO RURAL</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODSBORO RURAL</u>	
		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROSCOE L. RIPPEON</u>		4. DATE OF DEATH Month Day Year <u>MAY 2 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 21-1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BRADLEY T RIPPEON</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA FRITZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-36-8623</u>	
17. INFORMANT <u>ANNIE S RIPPEAN</u>		Address <u>RURAL WOODSBORO MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. j. p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19 _____ to _____, 19 _____ that I last saw the deceased alive on _____, 19 _____ and that death occurred at _____ M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>J. H. MESSLER</u>		M.D. <u>John Bridge</u>	
PHYSICIAN'S NAME (Type) <u>J. H. MESSLER M.D.</u>		<u>Wm. Bridge</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 6-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>UNION CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>LIBERTYTOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartzler Sons</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 6 1958</u>	
ADDRESS <u>Libertytown Md</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Bridge</u>	





5727

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Braddock Heights</b>		c. LENGTH OF STAY IN 1b <b>3 Years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>1003 Rosemont Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Vindobona Convalescent &amp; Rest Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Estella Lena Burkhardt Sanner</b> (Also Known As <b>Stella Burkhardt Sanner</b> )		4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 May 1876</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Joseph E. Staley</b>	
14. MOTHER'S MAIDEN NAME <b>Clara A. C. (Last Name Unknown)</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Staley V. Sanner (Same as Item #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio Vascular Renal Disease</b> DUE TO (c) <b>Sclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>Jan 10, 1955</b> , to <b>May 27, 1958</b> , that I last saw the deceased alive on <b>May 27, 1958</b> , and that death occurred at <b>3 P. M.</b> from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) <b>17 E. Second St. Frederick, Md.</b>		DATE SIGNED <b>28 May 1958</b>	
ACTUAL SIGNATURE <b>H. L. Fahrney, M.D.</b>		PHYSICIAN'S NAME (Type) <b>H. L. Fahrney, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-29-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 2 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alb. Leach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5728

CERTIFICATE OF DEATH

05709

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Braddock Heights</b>		c. LENGTH OF STAY IN 1b <b>9 weeks</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Buckeystown</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Vindobona Convalescent Home</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>19 58</b>	
3. NAME OF DECEASED (Type or print) First <b>Ossie</b> Middle <b>Anna</b> Last <b>Shankle</b>	5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		
8. DATE OF BIRTH <b>9-12-1883</b>		9. AGE (In years last birthday) <b>74</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nelson B. Ponton</b>		14. MOTHER'S MAIDEN NAME <b>Mary Grant</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Harry D. Shankle-Buckeystown</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coracoid Dilatation</b> <b>442x</b> DUE TO (b) <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Cardio Vascular Renal Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>3 month</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Abdominal Hernia</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 31, 1958</b> , to <b>May 7, 1958</b> , that I last saw the deceased alive on <b>May 7, 1958</b> , and that death occurred at <b>12:05 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. L. Fahrney</b>		ADDRESS (Street, city or town, state) <b>17 E. Second St. Frederick Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. H. L. Fahrney</b>		DATE SIGNED <b>17 East 2nd Street, Frederick, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 10-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>		24a. REC'D BY REGISTRAR <b>MAY 9 '58</b>	
ADDRESS <b>Frederick-Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5729

Reg. Dist. No. 05710

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Highway-Rt.15- Frederick- (North)</b>		e. STREET ADDRESS <b>P.O. Adamstown</b>	
3. NAME OF DECEASED (Type or print) <b>William LeRoy Smith</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <del>DATE OF BIRTH</del> <b>July 4-1915</b>	9. AGE (In years last birthday) <b>42</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Smith</b>		14. MOTHER'S MAIDEN NAME <b>Violet Fair</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes W. War 11</b>		16. SOCIAL SECURITY NO. <b>205-09-4016</b>	17. INFORMANT <b>Mrs. Ruth Hoke Fair-399 S. Washington St.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture base of Skull</b> <b>823x</b> DUE TO <b>Fracture left thigh</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Crushed Chest</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile ran into a tree</b>	
20c. TIME OF INJURY Month, Day, Year <b>1-10 a.m. 5/10 1958</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 15</b>	20f. (City or town) (County) (State) <b>Frederick Frederick Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B. D. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. D. Thomas</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 14-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
24a. REC'D BY REGISTRAR <b>5/14/58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Hoke</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05711

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croagerstown</u>	c. LENGTH OF STAY IN 1b <u>50 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>May</u> Last <u>Speaks</u>		4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 2-1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>John Valentine</u>		14. MOTHER'S MAIDEN NAME <u>Laura V. Creager</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-16-0502</u>	
17. INFORMANT <u>Mrs. Milton Grimes</u>		Address <u>Thurmont, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B. D. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. D. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-1-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>United Brethren Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Thurmont, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>		ADDRESS <u>Thurmont, Md.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>JUN 2 '58</u>			

DATE SIGNED

May 29, 1958

THE STATE  
OF NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Faint, mostly illegible text and markings on a medical certificate form, including fields for patient information, cause of death, and examiner details.]*

*[Vertical text on the right margin, likely a filing or archival stamp, including the words "RECEIVED" and "FILED".]*

## CERTIFICATE OF DEATH

Reg. Dist. No.

05712

5690

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick County Chronic Hospital</b>				e. STREET ADDRESS <b>124 East Seventh Street</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>AGNES</b> Last <b>SPURRIER</b>				4. DATE OF DEATH Month <b>May 19,</b> Day <b>19</b> Year <b>58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 4, 1877</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John W. Layman</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Poole</b>			
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Rosco C. Spurrier—Same as Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis.</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1928</b> , to <b>May 19, 1958</b> , that I last saw the deceased alive on <b>May 19, 1958</b> , and that death occurred at <b>10:35 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>North Market Street, Frederick, Maryland</b> DATE SIGNED <b>5/21/1958</b>							
ACTUAL SIGNATURE <b>H. F. Kline</b>				M.D. <b>North Market Street, Frederick, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Dr. H. F. Kline</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 22, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frederick Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 22 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 5731 CERTIFICATE OF DEATH

Reg. Dist. No. 05713

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural (Burkittsville)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Burkittsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -		d. STREET ADDRESS -	
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>Ruch</b> Last <b>Staley</b>		4. DATE OF DEATH Month <b>5</b> Day <b>1</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-10-1876</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>1</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Jacob Ruch</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Martin</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>William T. Staley, Burkittsville, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>578X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction from</b> DUE TO <b>3 yrs</b> (c) <b>arteriosclerosis - came on</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-1-1958</b> to <b>5-1-1958</b> , that I last saw the deceased alive on <b>4-30-1958</b> , and that death occurred at <b>12:55A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. E. Pruitt</b>		DATE SIGNED <b>5-1-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-3-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Marks</b>
22d. LOCATION (City, town, or county) (State) <b>nr. Petersville, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Foster</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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*Journal of Management Education*

William T. Butler, Buckle Up, Inc.

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6244 • J. Neurosci., September 24, 2008 • 28(39):6239–6248

• [bw.elliott@ed.ac.uk](mailto:bw.elliott@ed.ac.uk)

5698

## CERTIFICATE OF DEATH

Reg. Dist. No.

05714

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>				c. LENGTH OF STAY IN 1b <b>35</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>13 N. Virginia Avenue</b>				d. STREET ADDRESS <b>13 N. Virginia Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carrie Mae Stewart</b>				4. DATE OF DEATH Month Day Year <b>5-1-1958 19</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-6-1889 1888, 69/69/79</b>	
9. AGE (In years lost birthday) <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Jasper L. Dern</b>				14. MOTHER'S MAIDEN NAME <b>Alice Few</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Ethel Strailman, Brunswick, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331x</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2 3/4</b>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/16</b> , 19 <b>57</b> , to <b>5/1</b> , 19 <b>58</b> , that I lost saw the deceased alive on <b>5/1</b> , 19 <b>58</b> , and that death occurred at <b>4:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Brunswick, Maryland</b> DATE SIGNED <b>5/3/58</b> ACTUAL SIGNATURE <b>J.G.F. Smith</b> M.D. <b>James F. Smith</b> PHYSICIAN'S NAME (Type) <b>J.G.F. Smith</b> <b>Brunswick, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-4-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Feste</b> <b>Brunswick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5691 CERTIFICATE OF DEATH

05715

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Sylvester</b> Last <b>Stine</b>				4. DATE OF DEATH Month <b>May</b> Day <b>21st.</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <del>MARRIED</del> <input checked="" type="checkbox"/> <del>NEVER MARRIED</del> <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <del>RE-MARRIED</del> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 22-1882</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lawson P. Stine</b>				14. MOTHER'S MAIDEN NAME <b>Laura Routzahn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-5926</b>		17. INFORMANT <b>Richard Williams- Ridge Rd.-BraddockHghts.-Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary vascular accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1956</b> , to <b>5/21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5/20</b> , 19 <b>58</b> , and that death occurred at <b>1:10A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Bldg.</b> DATE SIGNED <b>5-22-58</b> ACTUAL SIGNATURE <b>James B. Thomas</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. James B. Thomas</b> <b>Frederick-Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 23-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick-Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Cline &amp; Son</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05716

5692

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Enroute to Frederick Mem. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>David</b> Last <b>Stull</b>				4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. <del>NEVER MARRIED</del> <input checked="" type="checkbox"/> <del>NEVER MARRIED</del> <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>July 5-1890</b>		9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Naval Gun Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carlton L. Stull</b>				14. MOTHER'S MAIDEN NAME <b>Mary Margaret Kolb</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>A.B.Collins-Frederick-Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Artero-sclerotic heart disease</b> (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B. O. Thomas, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>5/6/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 8-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>				ADDRESS <b>Frederick- Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 7 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. J. Leach</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



5732

## CERTIFICATE OF DEATH

Reg. Dist. No. 05717

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont, Rural</b>				c. LENGTH OF STAY IN 1b <b>75 yrs.</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont RD 2</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>/</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>William Aaron</b> First Middle Last <b>STULL</b>				4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1958</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 22, 1876</b>	
9. AGE (In years last birthday) <b>82</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John M. Stull</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Eigenbrode</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>219-20-0376</b>		17. INFORMANT Address <b>Mrs. Clara Schumaker Thurmont, Md. RD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic pneumonia</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral hemorrhage</b> DUE TO (c) <b>Hypertension</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 days</b> <b>?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerosis, generalized myocardial ischemia</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 22, 1958</b> , to <b>May 22, 1958</b> , that I last saw the deceased alive on <b>May 22, 1958</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Thurmont, Md.</b> DATE SIGNED <b>5/23/58</b>							
ACTUAL SIGNATURE <b>M. Franklin Birely</b> M.D.							
PHYSICIAN'S NAME (Type) <b>M. FRANKLIN BIRELY</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-25-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>United Brethren Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>				ADDRESS <b>Thurmont, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 27 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Quinn</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 5693 CERTIFICATE OF DEATH

Reg. Dist. No. 05718

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Weverton (Rural)</u> <u>21X-2</u>				d. STREET ADDRESS <u>Weverton Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>TILGHMAN</u> Last <u>THOMPSON</u> <u>John Thompson</u>				4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 25, 1905</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B.&amp;O. Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Weverton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John William Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Martha Elizabeth Holder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u> <u>705-10-3033</u>		17. INFORMANT <u>Mrs. Pearl Thompson</u> <u>Box 388, RFD #1, Knoxville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/27</u> , 19 <u>58</u> , to <u>5/31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/30</u> , 19 <u>58</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>5/31/58</u> ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D. <u>Frederick Maryland</u> PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brownsville Heights</u>		22d. LOCATION (City, town, or county) (State) <u>Brownsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald Cackler</u> ADDRESS <u>Harpers Ferry West Va.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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521-2001-22-7C

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John William Thompson

2005

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1971/1972 11.10.1971

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5733

## CERTIFICATE OF DEATH

Reg. Dist. No. 05719

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson-Rural-R.D.#1</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Lander Road</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson-Rural-R.D.#1</b>			
f. STREET ADDRESS <b>Lander Road</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>VIRGINIA</b> Last <b>THRASHER</b>				4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 1, 1895</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>4</b> Hours <b>2</b> Min.		11. IF UNDER 24 HRS. Months <b>3</b> Days <b>4</b> Hours <b>2</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Cephus E. Lakin</b>				14. MOTHER'S MAIDEN NAME <b>Flora B. Souder</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-36-2496</b>			
17. INFORMANT <b>Mrs. George Edward Thrasher-Same as Item #1</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> (c) <b>Hypertensive C.V. Disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>3 yrs</b> <b>10 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Alcohol</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>6/4</b> , 19 <b>57</b> , to <b>5/24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5/24</b> , 19 <b>58</b> , and that death occurred at <b>7:00 P.</b> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Jefferson, Maryland</b>			
ACTUAL SIGNATURE <b>A. T. Brice</b>				DATE SIGNED <b>5/26/58</b>			
PHYSICIAN'S NAME (Type) <b>Dr. A. T. Brice</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 27, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Jefferson, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH Baltimore		DEPARTMENT OF HEALTH BALTIMORE	
NAME OF DECEASED William J. ...		SEX Male	
DATE OF DEATH ...		TIME OF DEATH ...	
PLACE OF BIRTH ...		AGE ...	
OCCUPATION ...		CAUSE OF DEATH ...	
SIGNATURE OF PHYSICIAN ...		SIGNATURE OF REGISTRAR ...	
DATE ...		TIME ...	

This certificate is to be filled out by the physician or other person authorized by the State Department of Health. It is to be filed in the office of the Registrar of the State Department of Health. The Registrar will issue a certificate of death to the family of the deceased. The certificate of death is a legal document which is required for the burial of the deceased. The certificate of death is also used for the purpose of determining the cause of death and for the purpose of recording the death in the vital statistics of the State.



## 5694 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>236 A North Market Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ANN</b> Middle <b>ELIZABETH</b> Last <b>TINNEY</b>				4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1887</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin F. Shelton</b>				14. MOTHER'S MAIDEN NAME <b>Anna Biser</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-30-9794</b>		17. INFORMANT Address <b>Mrs. Charles H. Thomas, Frederick R.D.#3, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 23, 1958</b> , to <b>May 25, 1958</b> , that I last saw the deceased alive on <b>May 25, 1958</b> , and that death occurred at <b>9:50A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Building</b> DATE SIGNED <b>5/26/58</b>							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. <b>Frederick, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 28, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAY 27 '58</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED PROBATION		2. SEX Male		3. AGE 35	
4. PLACE OF BIRTH PROBATION		5. DATE OF BIRTH 1900		6. DATE OF DEATH 1935	
7. PLACE OF DEATH PROBATION		8. CAUSE OF DEATH TUBERCULOSIS		9. MANNER OF DEATH Natural	
10. OCCUPATION None		11. EDUCATION None		12. RELIGION None	
13. MARITAL STATUS Single		14. COLOR White		15. HEIGHT 5' 10"	
16. WEIGHT 150		17. BUILD Slender		18. COMPLEXION Fair	
19. PREVIOUS ILLNESS Tuberculosis		20. PRESENT ILLNESS Tuberculosis		21. MEDICAL HISTORY Tuberculosis	
22. PHYSICIAN'S NAME Dr. J. H. Jones		23. HOSPITAL NAME None		24. PLACE OF INTERMENT None	
25. SIGNATURE OF PHYSICIAN J. H. Jones		26. SIGNATURE OF DECEASED None		27. SIGNATURE OF WITNESSES None	
28. SIGNATURE OF REGISTRAR None		29. SIGNATURE OF CLERK None		30. SIGNATURE OF JUDGE None	

OFFICE OF THE REGISTRAR

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof to be sent to the local health officer of the city or county in which the deceased resided at the time of death.

## 5695 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick County Chronic Hospital</b>				d. STREET ADDRESS <b>110 West 13th Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>ROSEANA</b> Last <b>UTTERBACK</b>				4. DATE OF DEATH Month <b>May</b> Day <b>21</b> , Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 16, 1889</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John L. Haberkorn</b>				14. MOTHER'S MAIDEN NAME <b>Emmeline Schuffler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Gary L. Utterback, Same as item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Polycthemic vera</b> <b>294X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bangrene left foot</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 Aug</b> , 19 <b>57</b> , to <b>21 May</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>20 May</b> , 19 <b>58</b> , and that death occurred at <b>2:05 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Walkersville, Maryland</b> DATE SIGNED <b>5/23/58</b>							
ACTUAL SIGNATURE <b>James E. Stoner, Jr.</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. James E. Stoner, Jr.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 23, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5696

## CERTIFICATE OF DEATH

05722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>11 Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>64 Taney Apts.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LUTHER H. M. WACHTER</u>		4. DATE OF DEATH Month Day Year <u>MAY 9, 1958</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 13, 1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>27</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob H. Wachter</u>		14. MOTHER'S MAIDEN NAME <u>Annie Roberts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-10-8125A</u>	
17. INFORMANT <u>Mary C. Wantz</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x Diabetic Acidosis</u> DUE TO (b) <u>UREMIA + INFECTION (URINARY)</u> DUE TO (c) <u>Benign Prostatic Hypertrophy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 9, 1958</u> , to <u>MAY 9, 1958</u> , that I last saw the deceased alive on <u>MAY 9, 1958</u> , and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert D. Crouch</u> M.D.		ADDRESS (Street, city or town, state) <u>101 Frederick Shopping Center</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT D. CROUCH</u>		DATE SIGNED <u>5/9/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 13, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Utica and Reformed</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Dailey</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 14 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. C. Crouch</u>			



CERTIFICATE OF DEATH

<p>NAME OF DECEASED <b>Robert D. Green</b></p>		<p>DATE OF DEATH <b>May 2, 1928</b></p>	
<p>AGE <b>42</b></p>		<p>SEX <b>Male</b></p>	
<p>DATE OF BIRTH <b>May 2, 1886</b></p>		<p>PLACE OF BIRTH <b>Frederick, Maryland</b></p>	
<p>CAUSE OF DEATH <b>Diabetic Acidosis</b></p>		<p>IMMEDIATE CAUSE <b>Uremia &amp; Intoxication (Uremic)</b></p>	
<p>UNDERLYING CAUSE <b>Benign Prostatic Hypertrophy</b></p>		<p>PREVIOUS ILLNESS <b>Diabetes Mellitus</b></p>	
<p>DATE OF INTERMENT <b>May 2, 1928</b></p>		<p>PLACE OF INTERMENT <b>Greenwood Cemetery, Baltimore, Md.</b></p>	
<p>NAME OF PHYSICIAN <b>Dr. J. H. Green</b></p>		<p>NAME OF FUNERAL HOME <b>Green &amp; Sons</b></p>	
<p>NAME OF WITNESS <b>Dr. J. H. Green</b></p>		<p>NAME OF WITNESS <b>Dr. J. H. Green</b></p>	

Frederick

Frederick

e. IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☐

111 Ice Street

111 Ice Street

Month	Day	Year
May	13	19 58

ROOF	MIN.
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12. CITIZEN OF WHAT COUNTRY?

Frederick, Md.

Harriett Green

Address

Ruth G. Dixon -- 111 Ice Street Fred. Md.

INTERVAL BETWEEN  
ONSET AND DEATH

Year \_\_\_\_\_

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☐

(State)

DATE SIGNED

Frederick, Maryland

(State)

24b. REGISTRAR'S SIGNATURE

DATE \_\_\_\_\_

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES D. THOMAS, JR.		AGE 35		SEX Male		RACE White		DATE OF DEATH May 15, 1958		PLACE OF DEATH Home	
RESIDENCE 1234 Elm Street, Baltimore, Md.		OCCUPATION Salesman		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		CERTIFICATE NO. 12345		REGISTRATION NO. 67890	
DATE OF BIRTH May 15, 1923		PLACE OF BIRTH Baltimore, Md.		EDUCATION High School		MARRIAGE Married		SPOUSE Mary D. Thomas		CHILDREN None	
PREVIOUS ILLNESS None		TREATMENT None		HISTORY OF PRESENT ILLNESS Onset of chest pain on May 14, 1958, at 10:00 AM. Pain increased and was accompanied by sweating and shortness of breath. Death occurred at 11:00 AM.		HISTORICAL FACTS None		LABORATORY EXAMINATIONS None		PATHOLOGICAL FINDINGS None	
SIGNATURE OF PHYSICIAN J. D. Smith, M.D.		SIGNATURE OF REGISTRAR J. D. Smith, M.D.		SIGNATURE OF DECEASED None		SIGNATURE OF WITNESSES None		SIGNATURE OF FUNERAL HOME None		SIGNATURE OF CLERK None	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5734

## CERTIFICATE OF DEATH

Reg. Dist. No.

05724

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural—Lewistown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt. 1 Thurmont</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Eli. Armenius Wolfe</b>		4. DATE OF DEATH <b>May 14</b> 19 <b>58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 6-1883</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fish Hatchery</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fish Hatchery Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Lewistown-Fred. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Calvin A. Wolfe</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Anne Ricketts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mae Ambush Wolfe—Thurmont</b>		Address <b>Rt. 1 Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 10</b> , 19 <b>58</b> , to <b>May 14</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 13</b> , 19 <b>58</b> , and that death occurred at <b>3: A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Bernard O. Thomas</b> M.D.			
PHYSICIAN'S NAME (Type) <b>DR. B. O. Thomas JR.</b> <b>228 N. MARKET STREET</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 17-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fairview</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks III</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 19 58</b>	
ADDRESS <b>Frederick, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>W. S. Smith</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5735

## CERTIFICATE OF DEATH

Reg. Dist. No. **05725**

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural--Mt. Airy</b>		c. LENGTH OF STAY IN 1b <b>29yrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x Rural--Mt. Airy</b>		d. STREET ADDRESS <b>Bill Moxley Rd.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Walter</b> First <b>E. Wright</b> Middle <b>Walter</b> Last		4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-1-1897</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James E. Wright</b>		14. MOTHER'S MAIDEN NAME <b>Vinnie R. Wolfe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>215-09-1020</b>	
17. INFORMANT <b>Mrs. Helen E. Wright,</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Pulmonary Oedema</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>18 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 25</b> , 19 <b>56</b> , to <b>May 13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 6</b> , 19 <b>58</b> , and that death occurred at <b>10:52P</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9 E. Church St. Frederick, Md.</b> DATE SIGNED <b>5/14/58</b>			
ACTUAL SIGNATURE <b>H. J. Slusher</b>		PHYSICIAN'S NAME (Type) <b>H. J. SLUSHER</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5-16-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Marvin Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 19 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

